To Accept or to Reject?

What should we do when faced with difficult end-of-life decisions? An expert speaks.

By Juan Guajardo

To most people, the duty of medicine is to fight illness and by extension, its companion, death.

But what happens when it can't? And are there times when it shouldn't? Are there times when the proposed intervention's unintended consequences outweigh its benefits?

Father Tad Pacholczyk, bioethics expert and director of education for the National Catholic Bioethics Center, recently answered those questions during the local "Do No Harm" conference on end-of-life issues and the Catholic Church's teachings related to them.

The September conference was sponsored in part by the Respect Life Office of the Diocese of Fort Worth.

FIGHT TO THE DEATH?

Fr. Tad said we live in a society that largely denies suffering and death and avoids the end-of-life conversation. Oftentimes, this expresses itself in the medical arena as a fierce fight for the slender odds of living longer rather than preparing the patient — and their family — for the much more probable outcome: death.

"In a war that you cannot win, you don't want a general who fights to the point of total annihilation. You don't want Custer. You want Robert E. Lee — someone who knew how to fight for territory when he could and how to surrender when he couldn't. Someone who understood that the damage is greatest if all you do is fight to the bitter end," Fr. Tad quoted from Dr. Atul Gawande's 2010 *New Yorker* article, "What Should Medicine Do When It Can't Save You?"

While there's nothing wrong with medicine — or a terminal patient's family — looking for the small possibility of overcoming that diagnosis, sometimes "we need to focus our energy on preparing for

death," he said.

The U.S. Conference of Catholic Bishops' *Ethical and Religious Directives on Catholic Health Care Services* provides guidance in those situations. In it, the bishops state the "truth that life is a precious gift from God," that "we're not the owners of our lives and, hence, do not have absolute power over life. We have a duty to preserve our life and to use it for the glory of God, but the duty to preserve life is not absolute."

In other words, if a life-prolonging medical procedure is "insufficiently beneficial or excessively burdensome," we may reject it, Fr. Tad explained.

But being good stewards of the gift of life, especially in end-of-life situations, is oftentimes more difficult and nuanced than imagined.

"This stuff's not easy on first glance," Fr. Tad said. "You've got to consult with some experts. You've got to have some input from others, maybe from some clergy. You've got to spend some time on this, and if you do that and bring it to prayer, the gray shrinks to a line. And you see where that line is between right and wrong and then you end up choosing in a good way for your mom or dad or whoever it is who is dying."

If we're generous in that due-diligence, "we'll definitely find that clarity because, remember, the Lord God does not leave us in some kind of a vacuum in these hugely important moments of our lives where our loved ones, or we ourselves, are dying," he added.

PROPORTIONATE AND DISPROPORTIONATE

One key criterion to look at when making difficult treatment decisions is the distinction between proportionate and disproportionate means. Context like age, reasonable chance of success, risks and side effects, physical and emotional state of the sick person, and expense are factors in determining whether an intervention or surgery is proportionate, and therefore necessary, or disproportionate and therefore optional.

"If something is proportionate or ordinary we say it is required, you need to do this to be a good steward," Fr. Tad said. "On the other hand, if something is disproportionate, or extraordinary, it's optional. And please understand what that means when we say it's optional. When you say, 'I am not doing that surgery because I believe it is disproportionate'... you do not commit any sin. It's very important to be clear on that."

Ethical-Religious Directives 56-58 in the bishops' document shine additional light on the question of proportional vs. disproportional and how burden and benefit play a role in the decision-making process — especially important since there is no "Letterman Top 10" list of extraordinary or disproportionate interventions, Fr. Tad explained. Rather, the ordinary or extraordinary status of an intervention depends on the "concrete details of this patient, in this bed, at this moment, with this constellation of issues going on. So it's context dependent."

"So they're offering you a surgery and you're saying to yourself, 'Well what are the chances this will work?' Is this what we call the standard of care, or is this perhaps something highly experimental with only a 1-in-300 chance that it's going to benefit a person?" he said. "As much of that information as you can get ahold of upfront will be very, very important to have."

Ethical-Religious Directives on End-of-Life Care

56. A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community.

57. A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient's judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community.

58. In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally.... Medically assisted nutrition and hydration become morally optional when they cannot reasonably be expected to prolong life or when they would be "excessively burdensome for the patient or [would] cause significant physical discomfort, for example resulting from complications in the use of the means employed...."

To read the rest of the U.S. Bishops' Ethical and Religious Directives on Catholic Health Care Services, visit:
USCCB.org/about/doctrine

CALLED TO PRUDENCE

By considering an intervention's benefits and risks, an individual (whether that's the patient himself or the proxy) can find clarity in making a judgment.

"And notice that last word: judgment," Fr. Tad said. "What we are doing here, what we're seeking to do is to make a good prudential judgment," that is, a decision made with knowledge of right and wrong.

"To the extent that we [practice] the due diligence that I was talking about, invest ourselves wholeheartedly into the struggle, bring it to prayer, and exercise that virtue of prudence, we can very much be at peace when that day finally does come that our loved one dies," and know the decision was appropriate, he said.

"Later when you die and hopefully meet your mom and your dad again, they'll be able to say to you, 'You took good care of me. Thank you for what you did as I was dying. It was a good death.' What a beautiful thing that is. So, prudence in making that good judgment is our call."